

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellerslie</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellerslie, Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Alice</u> (Middle) <u>Caroline</u> (Last) <u>Albright</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 17 1873</u>
9. AGE last birthday <u>78</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Hayman</u>		14. MOTHER'S MAIDEN NAME <u>Margaret unknown</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Clifford Albright</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause		(a) <u>Chronic Arterio Sclerotic Cardio-Cerebral Disease</u>	
Antecedent cause(s) <u>442X</u>		(b) <u>131a</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)	
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>1951</u> , to <u>5/18</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5/18/51</u> , 19 <u>51</u> , and that death occurred at <u>3:30</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>John A. Topper MD</u>		ADDRESS <u>Hyndman Rd</u> DATE SIGNED <u>5/20/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 21/1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) <u>Cumberland Md</u>	
DATE REC'D BY LOCAL REG. <u>May 19, 1951</u>		REGISTRAR'S SIGNATURE <u>J. Lloyd Wolfe</u>	
24. FUNERAL DIRECTOR <u>Louis Stein, Inc</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 25 1951
BUREAU OF
F. I. & S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL		STREET ADDRESS (If rural, give location) 10 EAST STREET	
3. NAME OF DECEASED (Type or Print) Loretta Belle		4. DATE OF DEATH (Month) 5 (Day) 5 (Year) 1951	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH 9/19/1878
9. AGE last birthday 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWARD DRAKE		14. MOTHER'S MAIDEN NAME CATHERINE IMES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Operative Pneumonia	6 mos.
Antecedent cause(s) (b) 292.4 Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	
(c) 73d	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1-29-51 , 19 51 , to 5-5-1951 , that I last saw the deceased alive on 5-5-1951 , and that death occurred at 12:25 P.m. , from the causes and on the date stated above.			
SIGNATURE Wm. F. Williams M.D. Cumberland	(Degree or title)	ADDRESS 555	DATE SIGNED 5-5-51
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF May 8, 1951	NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. May 7, 1951	REGISTRAR'S SIGNATURE Wm. F. Williams M.D.	24. FUNERAL DIRECTOR John J. Hager, Cumberland, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04402

Reg. Dist. No. 4

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE PENNSYLVANIA COUNTY BEDFORD	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ARTEMAS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) AMANDA	(Middle) W.	(Last) BENNETT
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH 10/20/1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE last birthday 79 yrs.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME ISAAC WILSON		14. MOTHER'S MAIDEN NAME CATHERINE ASH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL			

15. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Myocardial Failure	24 hrs
Antecedent cause(s) (b) Chronic Atherosclerosis	Unknown
(c) None	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **5/18/51**, 19**51** to **2/9/51**, 19**51**, that I last saw the deceased alive on **2/9/51**, 19**51**, and that death occurred at **Artemas, Pa.**, from the causes and on the date stated above.

SIGNATURE R. E. Rees	DATE SIGNED 5/18/51
23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE THEREOF May 12, 1951
NAME OF CEMETERY OR CREMATORY Artemas Cemetery	LOCATION (City, town, or county) (State) Artemas, Pa.
DATE REC'D BY LOCAL REG. May 12, 1951	REGISTRAR'S SIGNATURE Walter R. Mandy, M.D.
24. FUNERAL DIRECTOR John J. Hager, Cumberland, Md.	

MARGIN RESERVED FOR BINDING

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04403

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Barton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Barton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Barton</u>		STREET ADDRESS (If rural, give location) <u>Barton</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>HARRY</u>	(Middle) <u>DAVID</u>	(Last) <u>BERRY</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 18, 1884</u> 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Charles Berry</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Samuel M. Berry, Barton, Maryland</u>	
16. SOCIAL SECURITY NO. <u>214-03-1502</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Gwyn</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Myocardial infarction</u>	<u>8 days</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Coronary Occlusion</u>	<u>"</u>
	(c) <u>Coronary Sclerosis</u>	<u>"</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) _____ (COUNTY) _____ (STATE) _____
TIME (Month) (Day) (Year) (Hour) OF INJURY _____ m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from May 12, 1951, to May 19, 1951, that I last saw the deceased alive on May 19, 1951, and that death occurred at 6 P. m., from the causes and on the date stated above.

SIGNATURE Norman Reenes, M.D. ADDRESS Westernport Md DATE SIGNED 5/22/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF May 22, 1951 NAME OF CEMETERY OR CREMATORY Philos Com LOCATION (City, town, or county) (State) Westernport, Maryland

DATE REC'D BY LOCAL REG. May 22, 1951 REGISTRAR'S SIGNATURE Mar Jon C. Kelly 24. FUNERAL DIRECTOR E.S. Boal ADDRESS 111 Church St. Westernport, Maryland

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU W. S.

JUL 28 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04404

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland - Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany Hospital</u>		STREET ADDRESS (If rural, give location) <u>RD#2 Williams Road</u>	
3. NAME OF DECEASED (First) <u>George</u> (Middle) <u>R.</u> (Last) <u>Bottenfield</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>9</u> (Year) <u>1951</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>October 5, 1901</u>
9. AGE last birthday <u>49</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Rural - Near Cumberland, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Palmer W. Bottenfield</u>		14. MOTHER'S MAIDEN NAME <u>Harriett E. North</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs George R. Bottenfield Rt#2</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

9 days

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-3, 1951, to 5-9, 1951, that I last saw the deceased

alive on 5-9, 1951, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION (REMOVAL SECTION)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 12, 1951 Walter R. Dantz, M.D.

John J. Hofer, Cumberland, Md.

100105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.
MAY 15 1951

Johnson
or
Ashtabula

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04405

Reg. Dist. No. 6

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D.1</u> TOWN <u>Westernport</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D.1 Westernport</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>In Georges Creek near Brophytown (rural)</u>				STREET ADDRESS (If rural, give location) <u>Brophytown. (rural)</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>William</u>		(Middle) <u>Michael</u>		(Last) <u>Bowley</u>	
4. DATE OF DEATH		(Month) <u>May</u>		(Day) <u>8</u>		(Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>July 10-1948</u>	9. AGE last birthday <u>2</u> yrs.	If under 1 year Months	If under 24 hrs Days	If under 24 hrs Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Piedmont, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William Henry Bowley</u>			
14. MOTHER'S MAIDEN NAME <u>Betty Keller</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY No. <u>none</u>				17. INFORMANT AND ADDRESS <u>Mother) Betty K. Bowley</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>Asphyxia due to accidental drowning.</u>						<u>about 3 min.</u>	
(b) <u>Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>							
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY * OR CONTRIBUTING * <input type="checkbox"/>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>near (rural)</u>		CITY OR TOWN <u>Westernport</u>		COUNTY <u>Allegany</u> STATE <u>Md.</u>	
CAUSE OF DEATH.		INJURY <u>Georges Creek</u>		HOW DID INJURY OCCUR? <u>Presume, fell off of swinging bridge into Georges Creek.</u>			
TIME (Month) (Day) <u>May 8/51</u>		INJURY OCCURRED <u>P. m.</u>		While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection* <input type="checkbox"/> , Inquiry* <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE <u>H.V. Deming M.D.</u>				DATE SIGNED <u>May 8-1951</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>5/11/51</u>		NAME OF CEMETERY OR CREMATORY <u>Philos Cem.</u>		LOCATION (City, town, or county) (State) <u>Westernport Md</u>	
DATE REC'D BY LOCAL REG. <u>May 10, 1951</u>		REGISTRAR'S SIGNATURE <u>Marjorie C. Kelly</u>		24. FUNERAL DIRECTOR <u>Ellsworth S. Boal</u>		ADDRESS	

BUREAU W. S.

MAY 14 1961

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04409

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
TOWN <u>Cumberland</u>		TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>302 Columbia St.</u>		STREET ADDRESS (If rural, give location) <u>302 Columbia St.</u>	
3. NAME OF DECEASED (First) <u>Eladys</u> (Middle) <u>Gates</u> (Last) <u>Bowman</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>3-17-1892</u>
9. AGE last birthday <u>59</u> yrs.		10. If under 1 year: Months <u>8</u> Days <u>16</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Textile Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plant of Artificial Silk</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cyrus Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gates</u>	
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-2874</u>	
17. INFORMANT AND ADDRESS <u>Betty Bowman 302 Columbia St.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Carcinoma Cervix & metastasisINTERVAL BETWEEN ONSET AND DEATH 8 months

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/15, 1951, to 5/16, 1951, that I last saw the deceasedalive on 5/15, 1951, and that death occurred at 1:40 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 18, 1951Walter K. Lang, M.D.Louis Strain, Inc.Cumberland, Md.

690437

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 23 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

04406

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
TOWN <u>Frostburg</u>		TOWN <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miner's Hoospital</u>		STREET ADDRESS (If rural, give location) <u>264 E. Main St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Joseph</u> (First) <u>Matthew</u> (Middle) <u>Brady</u> (Last)		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>3</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>7-26-1882</u>
9. AGE last birthday <u>68</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>	
11. BIRTHPLACE (State or foreign country) <u>Eckhart, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Patrick Brady</u>		14. MOTHER'S MAIDEN NAME <u>Honora Kenney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-03-8013</u>	
17. INFORMANT AND ADDRESS <u>Frostburg, Md.</u>		18. Mr. James Brady, 264 E. Main St.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Carcinoma Lung</u>	<u>??</u>
Antecedent cause(s)	(b) <u>163X 47d</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 7, 1951, to May 3, 1951, that I last saw the deceased alive on May 2, 1951, and that death occurred at 5:40 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>	DATE THEREOF <u>5-5-1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cem.</u>	LOCATION (City, town, or county) <u>Frostburg, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>5-5-51</u>	REGISTRAR'S SIGNATURE <u>Mrs. Nancy A Roe</u>	24. FUNERAL DIRECTOR <u>Jacob Hafer</u>	ADDRESS <u>Frostburg, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

650216

RECEIVED

MAY 10 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH- COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage LENGTH OF STAY (in this place) 54 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Railroad St.

2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
STREET ADDRESS (If rural, give location) Railroad St.

3. NAME OF DECEASED (First) Mary (Middle) H. (Last) Bunall 4. DATE OF DEATH (Month) May (Day) 7 (Year) 1951

5. SEX F 6. COLOR OR RACE W 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed 8. DATE OF BIRTH July 23, 1884 9. AGE last birthday 66 yrs. If under 1 year: Months 0 Days 0 Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own home 11. BIRTHPLACE (State or foreign country) McKeesport, Pa. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Anthony Mcanyhan 14. MOTHER'S MAIDEN NAME Margaret Nicodemus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT AND ADDRESS Mrs. Helen Knepp, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) respiratory paralysis Interval BETWEEN ONSET AND DEATH 1 day

Antecedent cause(s) (b) degenerative brain disease 1 year

(c) cerebral arteriosclerosis 4 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1951, to May, 1951, that I last saw the deceased alive on May 2, 1951, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

SIGNATURE Doel Woelker (Degree or title) M.D. ADDRESS Frostburg Md. DATE SIGNED 5-9-51

23. BURIAL, CREMATION REMOVAL, (Specify) Burial DATE THEREOF May 10, 1951 NAME OF CEMETERY OR CREMATORY St. George Episcopal Cemetery LOCATION (City, town, or county) Mt. Savage (State) Md

DATE REC'D BY LOCAL REG. 5-10-51 REGISTRAR'S SIGNATURE Vermae McDemet 24. FUNERAL DIRECTOR John J. Hager, Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 14 1951
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

04408

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Ind.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>121 Wood St.</u>		STREET ADDRESS (If rural, give location) <u>121 Wood St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Mary</u> (Middle) <u>Catherine</u> (Last) <u>Casey</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-16-1876</u>
9. AGE last birthday <u>75</u> yrs.		10. If under 1 year: Months <u>5</u> Days <u>18</u> Hours <u>19</u> Min. <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick Gallagher</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann James</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Isadore Casey, 121 Wood St.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Chronic Myocarditis</u>		<u>6 mo</u>
Antecedent cause(s) (b) <u>Hypertension</u>		<u>2 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan, 1957, to May 18, 1957, that I last saw the deceased alive on May 18, 1957, and that death occurred at 6:00 P m., from the causes and on the date stated above.

SIGNATURE Wm C Lane M.D. ADDRESS Frostburg Md DATE SIGNED 5-21-51

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>5-21-1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Michael's</u>	LOCATION (City, town, or county) <u>Frostburg, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>5-22-51</u>		REGISTRARS SIGNATURE <u>Mrs. Nancy H. Roe</u>		24. FUNERAL DIRECTOR <u>Jacob Hafer, Frostburg, Md.</u>	

RECEIVED
MAY 24 1891
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 316 Holland St.		STREET ADDRESS (If rural, give location) 316 Holland St.	
3. NAME OF DECEASED (Type or Print) Charles Wesley Chenowith Sr.		4. DATE OF DEATH (Month) May (Day) 13 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 7-11-1880
9. AGE last birthday 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired Machinist	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Benjamin F. Chenowith		14. MOTHER'S MAIDEN NAME Mary L. Hughes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. 220-10-0531	
17. INFORMANT AND ADDRESS Mr. A. Edward Chenowith Cumberland			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Coronary occlusion		5 weeks
Antecedent cause(s) (b) Chronic Nephritis		2nd year
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Hypertensive heart disease		2nd year
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19 **48**, to **May 13, 1951**, that I last saw the deceased alive on **May 12, 1951**, and that death occurred at **5:25 P.m.**, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 5-16-1951	NAME OF CEMETERY OR CREMATORY Hillcrest Cem.	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. May 15, 1951	REGISTRAR'S SIGNATURE Winters R. Hartz, M.D.	24. FUNERAL DIRECTOR Charles L. George	ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

544-439

RECEIVED

MAY 23 1951

BUREAU V. S.

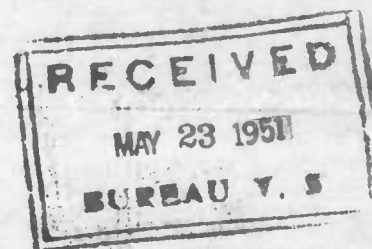
CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH- COUNTY		1. USUAL RESIDENCE (HOME) OF DECEASED- STATE		COUNTY	
ALLEGANY		PENNA		Bedford	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		TOWN HYNDMAN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		(If rural, give location)	
MEMORIAL HOSPITAL					
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)	
MINERVA		U		CLITES	
5. SEX		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		4. DATE OF DEATH (Month) (Day) (Year)	
FEMALE		MARRIED		MAY 17 1951	
6. COLOR OR RACE		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE last birthday (If under 1 year Months Days) (If under 24 hrs. Hours Min.)	
WHITE		none		55 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
None		PENNA		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
SAMUEL MILL		CATHERINE SMITH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS	
No		none		MEMORIAL HOSPITAL CUMBERLAND, MD.	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) Chronic Hepatitis					
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
581.1 106					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
Chronic Cholecystitis & Chronic Cholelithiasis					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
5/14/51		Hepatitis Severe Chronic Cholelithiasis - Cholecystitis		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
		INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 1945, to May 17, 1951, that I last saw the deceased alive on May 17, 1951, and that death occurred at 4:45 P.m., from the causes and on the date stated above.					
SIGNATURE		(Degree or title)		ADDRESS	
John A. Lopper		MD		Hyndman Pa	
DATE SIGNED				5/18/51	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		5/20/1951		Comps Cemetery	
LOCATION (City, town, or county) (State)		DATE REC'D BY LOCAL REG.		24. FUNERAL DIRECTOR	
Hyndman, RD#1, Pennsylvania		May 19, 1951		Walter R. Smith, M.D.	
ADDRESS				Hyndman, Pa.	



CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>W. Va.</u> COUNTY <u>Morganston</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Morganston</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>		STREET ADDRESS (If rural, give location) <u>806 Des Moines Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Armand</u> (First) <u>Joseph</u> (Middle) <u>Collett</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>May 18, 1926</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemist for the Kelley Springfield</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wire Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Morganstown, W. Va.</u>
13. FATHER'S NAME <u>Armand R. Collett</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY No. <u>236-32-6221</u>	
17. INFORMANT AND ADDRESS <u>Armond R. Collett, Morganstown, W. Va.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Severe contusion of the brain</u>		<u>4 days</u>
Antecedent cause(s) (b) <u>Automobile accident</u>		<u>4 days</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 21 1951</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Rural near Guntherstown</u>	(CITY OR TOWN) (COUNTY) (STATE) <u>Garrett Md.</u>
INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Loggy head on collision with another auto.</u>	

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>H. V. Downing M.D.</u>		DATE SIGNED <u>May 25, 1951</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5-28-1951</u>	
NAME OF CEMETERY OR CREMATORY <u>East Oak Grove</u>		LOCATION (City, town, or county) (State) <u>Morganstown W. Va.</u>	
DATE REC'D BY LOCAL REG. <u>5-25-51</u>		24. FUNERAL DIRECTOR <u>Davidson Funeral Ser. Morganstown W. Va.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU W. S.

MAY 20 1931

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04413

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) Frostburg		CITY (If outside corporate limits, write RURAL and give nearest town) Frostburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS E. Main St.		STREET ADDRESS (If rural, give location) E. Main St.	
3. NAME OF DECEASED (Type or Print)	(First) THOMAS	(Middle) E.	(Last) CONDON
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	4. DATE OF DEATH May 9, 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	10b. KIND OF BUSINESS OR INDUSTRY B&O shops	8. DATE OF BIRTH 10-3-1879	9. AGE last birthday 71 yrs.
13. FATHER'S NAME Michael Condon	14. MOTHER'S MAIDEN NAME Catherine Blake	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No. 705-07-2672	17. INFORMANT AND ADDRESS Joseph Condon, Frostburg, Md.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Arterio Sclerosis		2 years
Antecedent cause(s) (b) 450.1		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arterio Sclerotic Hypertension Rt Leg		9 mo
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct, 1950, to May 9, 1951, that I last saw the deceased alive on Apr 9, 1951, and that death occurred at 3:00 m., from the causes and on the date stated above.

SIGNATURE Wm C Lane MD	(Degree or title)	ADDRESS Frostburg Md	DATE SIGNED May 10 1951
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 5-11-51	NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery	LOCATION (City, town, or county) (State) Frostburg, Md.
DATE REC'D BY LOCAL REG. 5-11-51	REGISTRAR'S SIGNATURE Wm Nancy N. Roe	24. FUNERAL DIRECTOR J. R. Durst,	ADDRESS Frostburg, Md.

544506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

RECEIVED
MAY 15 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04414

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany County Infirmary</u>		STREET ADDRESS (If rural, give location) <u>Mexico Farms, R. F. D. #4</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ida</u> (Middle) <u>L.</u> (Last) <u>Crites</u>	4. DATE OF DEATH (Month) <u>5</u> (Day) <u>5</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 2, 1874</u> 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Mexico Farms, Md.</u>
13. FATHER'S NAME <u>Michael Long</u>		14. MOTHER'S MAIDEN NAME <u>Louise Stickley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>No ne</u>	
17. INFORMANT AND ADDRESS <u>James Crites Mexico Farms, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

6 days

4 hrs

4 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct. 4, 1950, to May 5, 1951, that I last saw the deceased alive on May 5, 1951, and that death occurred at 12:25 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-8-51</u>	NAME OF CEMETERY OR CREMATORY <u>Davis Memorial</u>	LOCATION (City, town, or county) <u>Cumberland Md.</u>
DATE REC'D BY LOCAL REG. <u>May 7, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>	24. FUNERAL DIRECTOR <u>Charles L. George - Cumberland Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.
MAY 15 1961
ST. ALB.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Pennsylvania</u> COUNTY <u>Clarke</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Utahville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegheny Hospital</u>		STREET ADDRESS (If rural, give location) <u>Route I</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Edith</u> (Middle) <u>May</u> (Last) <u>Crook</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>27</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 4, 1877</u>
9. AGE last birthday <u>74</u> yrs.		10. AGE under 1 year (Months) <u>1</u> (Days) <u>27</u> (Hours) <u>15</u> (Mins.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jesse Arnold</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Allegheny Hospital</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>congestive heart failure</u>	INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
Antecedent cause(s) (b) <u>arteriosclerotic heart disease</u>	<u>1 year</u>
(c) <u>stating the underlying cause last</u>	

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-4, 1950, to 5-27, 1957, that I last saw the deceased alive on 12-26, 1957, and that death occurred at 5 A m., from the causes and on the date stated above.

SIGNATURE L. Weiss (Degree or title) MD ADDRESS 5700 Penn D. DATE SIGNED 5-28-57

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 29, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor</u>	LOCATION (City, town, or county) (State) <u>Emmitsburg Maryland</u>
DATE REC'D BY LOCAL REG. <u>May 29, 1957</u>	REGISTRAR'S SIGNATURE <u>Walter R. Brant, M.D.</u>	24. FUNERAL DIRECTOR <u>Louis Steier, Inc.</u>	ADDRESS <u>Cumberland, Maryland</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1961
U.S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04416

Reg. Dist. No. 9

1. PLACE OF DEATH COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital		STREET ADDRESS None (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Margaret (First) R (Middle) Cunningham (Last)		4. DATE OF DEATH May 28 1951 (Month) (Day) (Year)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Aug. 29 1886 (Month) (Day) (Year)
9. AGE last birthday 64 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Ownhome	11. BIRTHPLACE (State or foreign country) Midland Md.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME James Edwards	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Wilbur Robertson	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 months
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Cancer of the gallbladder		
Antecedent cause(s) (b) 155X Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED White at Work <input type="checkbox"/> Not White <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1951, to May 28, 1951, that I last saw the deceased alive on May 28, 1951, and that death occurred at 4 p.m., from the causes and on the date stated above.

SIGNATURE Adolph Wolfman M.D. ADDRESS Frostburg Md. 5-29-51 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF May 31 1951	NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	LOCATION (City, town, or county) Frostburg MD.	(State)
DATE REC'D BY LOCAL REG. 5-29-51	REGISTRAR'S SIGNATURE <u>Nancy N. Roe</u>	24. FUNERAL DIRECTOR M. Eichhorn	ADDRESS Lonaconing MD.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1111

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RECEIVED

BUREAU W.S.S.

1111

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04417

1. PLACE OF DEATH- COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		LENGTH OF STAY (In this place) 2 HOURS <i>ALL LIFE</i>		CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural, give location) 131 PENNSYLVANIA AVENUE			
3. NAME OF DECEASED (Type or Print) HENRY		(First)		(Middle) A.		(Last) DAYTON	
4. DATE OF DEATH MAY		(Month)		(Day) 23		(Year) 1951	
5. SEX MALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH MARCH 17, 1902	
9. AGE last birthday 49		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R. CO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME R. T. DAYTON		14. MOTHER'S MAIDEN NAME SARAH V. LONG			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 705-09-9463		17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL-CUMBERLAND, MD.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

*Myocardial Infarction*INTERVAL BETWEEN
ONSET AND DEATH*2 hours*

Antecedent cause(s)

Disease or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b)

*coronary insufficiency**2 years*

(c)

*Arteriosclerosis & Hypertensive Ht. Disease**5 years*

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF
INJURYINJURY OCCURRED
While at
Work ☐ Not While
At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *May 22, 1951*, to *May 23, 1951*, that I last saw the deceasedalive on *May 23, 1951*, and that death occurred at *2:45 A.M.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*May 24, 1951**Winter K. Frank, M.D.**JAMES F. SCARPELLI, Cumberland*

544506

41.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 29 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04418

1. PLACE OF DEATH- COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Dawson		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Dawson	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt. 3 Keyser, W. Va.		STREET ADDRESS (If rural, give location) Rt. 3 Keyser, W. Va.	
3. NAME OF DECEASED (Type or Print)	(First) Lovilia	(Middle) Catherine	(Last) DeLawder
4. DATE OF DEATH	(Month) May	(Day) 23	(Year) 1951
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Apr. 26, 1879
9. AGE last birthday 72 yrs.		10. If under 1 year Months 0 Days 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Gard Co., W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Abraham Whitmer		14. MOTHER'S MAIDEN NAME Francelia Chrisman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mrs. Virginia Sowers, Dawson, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **Cerebral Hemorrhage**

Antecedent cause(s)

(b) **Hypertension**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) **Arteriosclerosis**

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **5/23/**, 19**51**, to **5/23**, 19**51**, that I last saw the deceased

alive on **5/23**, 19**51**, and that death occurred at **11 p.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 5/26/51	NAME OF CEMETERY OR CREMATORY Keyser, W. Va.	LOCATION (City, town, or county) Burlington, W. Va.	(State) W. Va.
DATE REC'D BY LOCAL REG. 5/28/51	REGISTRAR'S SIGNATURE Mrs. Jean C. Kelly	24. FUNERAL DIRECTOR Rogers Funeral Home, Keyser, W. Va.	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04419

The correct age of the deceased must be stated. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) Ellerslie		CITY (If outside corporate limits, write RURAL and give nearest town) Ellerslie	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Thomas J. Devore		4. DATE OF DEATH (Month) May (Day) 30 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, OR SEPARATED (Specify) Widowed	8. DATE OF BIRTH April 23, 1864
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Own Farm		10b. KIND OF BUSINESS OR INDUSTRY Farming	9. AGE last birthday 87 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Bedford Co., Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Daniel Devore		14. MOTHER'S MAIDEN NAME Rachel Devore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Mrs. Henry Lowery, Ellerslie, Md			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause Myocardial failure			5 days
(b) Antecedent cause(s) Coronary sclerosis			4 yrs
(c) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 12, 1950 , to May 30, 1951 , that I last saw the deceased alive on May 29, 1951 , and that death occurred at 6:30 a.m. , from the causes and on the date stated above.			
SIGNATURE Carl F. Jones		DATE SIGNED June 1, 1951	
23. BURIAL, CREMATION, OR OTHER (Specify) Burial		NAME OF CEMETERY OR CREMATORY Porter Cemetery	
DATE THEREOF June 1, 1951		LOCATION (City, town, or county) Hyndman, Pa.	
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.		ADDRESS 110 S. Centre St.	

MARGIN RESERVED FOR BINDING

VS. A15

100105

BUREAU W. S.

JUN 4 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04420

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>W.Va.</u> COUNTY <u>Mineral</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u> LENGTH OF STAY (In this place) <u>6 Hours</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Wiley Ford</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Circus Grounds, at the Taylor Tin Plate Mills</u>				STREET ADDRESS (If rural, give location) <u>✓</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>Earl</u> (Middle) <u>Victor</u> (Last) <u>Diehl</u>		4. DATE OF DEATH		(Month) <u>May</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>March 6-1891</u>	9. AGE last birthday <u>60</u> yrs.	If under 1 year Months <u> </u> Days <u> </u>	If under 24 hrs. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>		11. BIRTHPLACE (State or foreign country) <u>Friends Cove, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Phillip C. Diehl</u>			14. MOTHER'S MAIDEN NAME <u>Phoebe Lake</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1909-1912</u>			16. SOCIAL SECURITY No. <u>NONE</u>		17. INFORMANT AND ADDRESS <u>wife) Anna A. Swauger Diehl</u>		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute cardiac failure due to</u>		<u>at once</u>
Antecedent cause(s) (b) <u>Chronic myocarditis.</u>		<u>✓</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>93d</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐ * Inquiry * thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H.V. Deming M.D., H.V. Deming M.D., Cumberland, Md.		May 14-1951	
23. BURIAL, CREMATION OR MOVING (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5/17/51</u>	<u>Madley Cemetery</u>	<u>Madley Pa</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>May 17, 1951</u>	<u>Wm. L. Kartz, M.D.</u>	<u>William H. Right</u>	<u>Cumberland Md</u>

290636

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04421

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>871 Maryland ave</u>	
3. NAME OF DECEASED (First) <u>Andrew</u> (Middle) <u>Samuel</u> (Last) <u>Dolan</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Feb. 20 1907</u> 42 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursery Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Floral Nuthouse</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rosea H. Dolan</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Robinson</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes War II</u>		16. SOCIAL SECURITY No. <u>44-0000-0000</u>	
17. INFORMANT AND ADDRESS <u>H. H. Dolan 871 Maryland ave</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion 2 hrs
 420.1 Antecedent cause(s) II Alcoholism - Chronic moderate 24 hrs
 1176 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last II Duodenal Ulcer 7 hrs
 (8-10-51 ams)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4/19, 1951, to 5/20, 1951, that I last saw the deceased alive on 5/20, 1951, and that death occurred at 11:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 23 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Cumberland, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>May 22 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Jantz, M.D.</u>	24. FUNERAL DIRECTOR <u>Louis Stearns, Inc.</u>	ADDRESS <u>Cumberland, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

820105

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MAY 29 1964
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04422 9

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>		STREET ADDRESS (If rural, give location) <u>137 W. Main St.</u>	
3. NAME OF DECEASED (Type or Print) <u>WILLIAM</u> (First) <u>J.</u> (Middle) <u>DUGAN</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>3</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>7-24-1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>coal mines</u>	9. AGE last birthday <u>73</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> If under 24 hrs: Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Dugan</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Enfield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If year, give war or dates of service) <u> </u>		16. SOCIAL SECURITY No. <u>214-01-3632</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Leslie Smith, Barton, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary occlusion</u>		<u>3 days</u>
Antecedent cause(s) (b) <u>Chr. interstitial nephritis</u>		<u>6 mos.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>diabetes mellitus (mild)</u>		<u>3 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Silicosis?</u>		
19a. DATE OF OPERATION <u> </u>	19b. MAJOR FINDINGS OF OPERATION <u> </u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u> </u> PLACE (Home, farm, factory, street, office bldg., etc.) <u> </u> (CITY OR TOWN) <u> </u> (COUNTY) <u> </u> (STATE) <u> </u>	22. I hereby certify that I attended the deceased from <u>4:30</u> , 19 <u>51</u> , to <u>5:3</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5-3</u> , 19 <u>51</u> , and that death occurred at <u>3:50 P.M.</u> , from the causes and on the date stated above.	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u> </u> m. INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR? <u> </u>	SIGNATURE (Degree or title) <u>H.C. Diehl, M.D.</u> ADDRESS <u>Frostburg, Md.</u> DATE SIGNED <u>5/4/51</u>	

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>May 6 '51</u>	NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>	LOCATION (City, town, or county) <u>Frostburg, Md.</u> (State) <u> </u>
DATE REC'D BY LOCAL REG. <u>5-6-51</u>	REGISTRAR'S SIGNATURE <u>Mrs. Nancy A. Re</u>	24. FUNERAL DIRECTOR <u>J. R. Durst,</u>	ADDRESS <u>Frostburg, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

650216

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MAY 9 1961

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY ALLEGANY CUMBERLAND MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) CUMBERLAND		CITY (If outside corporate limits, write RURAL and give nearest town) LONACONING	
TOWN CUMBERLAND		TOWN LONACONING	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL		STREET ADDRESS (If rural, give location) EAST MAIN STREET	
3. NAME OF DECEASED (First) (Middle) (Last) MINNIE EICHHORN		4. DATE OF DEATH (Month) (Day) (Year) MAY 15 1951	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE		8. DATE OF BIRTH JAN 11, 1870	
9. AGE last birthday 81 yrs.		10. If under 1 year (Month) (Day) (Hour) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Care of furniture		10b. KIND OF BUSINESS OR INDUSTRY Undertaking Business	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME AUGUST EICHHORN		14. MOTHER'S MAIDEN NAME Shaffer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Broncho Pneumonia

4 days

Antecedent cause(s)

(b)

Chronic Myocardial Degeneration

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Chronic Valvular Heart Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

Generalized Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) **INJURY**

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5-1-**, 19**51**, to **5-15**, 19**51**, that I last saw the deceased

alive on **5-14**, 19**51**, and that death occurred at **4:00 A.** am., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

M.D. Williams M.D. Cumberland

5-15-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 16, 1951

Walter R. Lutz, M.D.

W. David Fredrick

Piedmont W.

054849

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MAY 23 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Cumberland</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Alleg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
TOWN <u>Cumberland</u>		TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hosp.</u>		STREET ADDRESS (If rural, give location) <u>823 Windsor Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Carrie</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Nov. 28 1865</u>	
9. AGE last birthday <u>85</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Burgunder</u>		14. MOTHER'S MAIDEN NAME <u>Dont know</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Lorraine Eisenberg</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Myocardial Failure

INTERVAL BETWEEN ONSET AND DEATH

6 mos.

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last.

Myocardial disease3 yrs?

(c)

Polyps stomach?

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Secondary Anemia, Abdominal Hernia (L)?

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY: Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 3, 1949, to May 18, 1951, that I last saw the deceasedalive on May 17, 1951, and that death occurred at 7:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 19, 1951Walter R. Rantz, M.D.Louis Stein Inc.Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MAY 23 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Rural - Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Frostburg</u>	
TOWN <u>Rural - Frostburg</u>		TOWN <u>Rural - Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Clarysville</u>		STREET ADDRESS <u>Clarysville</u>	
3. NAME OF DECEASED (Type or Print) <u>SOPHIA</u> (First) <u>(REPHANN)</u> (Middle) <u>ENGLE</u> (Last)		4. DATE OF DEATH <u>May</u> (Month) <u>27</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4-5-1860</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	9. AGE last birthday <u>91</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Eckhart, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Rephann</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lydinger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Lillian Seifarth, Frostburg, Md</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
Immediate cause (a) <u>Coronary occlusion</u>		
Antecedent cause(s) (b) <u>Atherosclerosis</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>4/20/11 94a</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 1950, to 27 May, 1951, that I last saw the deceased alive on 27 May, 1951, and that death occurred at 6:20 P.M., from the causes and on the date stated above.

SIGNATURE John B. Davis (Degree or title) M.D. ADDRESS Frostburg, Md DATE SIGNED 5/28/51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>5-29-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Zion Evan. & Ref. Cemetery</u>	LOCATION (City, town, or county) <u>Frostburg, Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>5-29-51</u>	REGISTRAR'S SIGNATURE <u>Mrs. Nancy A. Re</u>	24. FUNERAL DIRECTOR <u>J. R. Durst,</u>	ADDRESS <u>Frostburg, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
MAY 1 1951
BUREAU V. S.

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>516 Necessity St.</u>		STREET ADDRESS <u>516 Necessity St.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Earnest Robert Eversole</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 6 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 9-1894</u>
9. AGE last birthday <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver for the Cumberland</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emanuel Eversole</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Souders</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>214-05-4737</u>	
17. INFORMANT AND ADDRESS <u>wife) Geneieve Eversole</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>about 3 min.</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Coronary occlusion due to</u>			
Antecedent cause(s) (b) <u>Coronary sclerosis</u>			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>H.V. Deming M.D.</u>		DATE SIGNED <u>May 6-1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 9, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
DATE REC'D BY LOCAL REG. <u>May 7, 1951</u>		24. FUNERAL DIRECTOR <u>John J. Hefer, Cumberland, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 18 1961
BUREAU A. A.

MARYLAND STATE DEPARTMENT OF HEALTH

04427

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westernport-Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westernport Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1/4 Mi. E. of Westernport</u>		STREET ADDRESS (If rural, give location) <u>Cemetery rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Violet</u> (First) <u>Virginia</u> (Middle) <u>Fair</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>13</u> (Year) <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>19</u> <u>April 27, 17</u> <u>34</u> yrs.
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Office worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Dept.</u>	9. AGE last birthday If under 1 year Months Days Hours Min. <u>34</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>W.Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Harry Hook</u>		14. MOTHER'S MAIDEN NAME <u>Amy Poland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>218-18-2979</u>	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary and Generalized Edema

Antecedent cause(s)

(b) Chronic Myocarditis and Myocardial Degeneration(c) Specified as rheumatic diseases of other and unspecified valves and chronic Endocarditis, specified as rheumatic

INTERVAL BETWEEN ONSET AND DEATH

2 Days24 Years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	PLACE (Home, farm, factory, street, OF injury bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

20. AUTOPSY?

Yes ☐ No ☒22. I hereby certify that I attended the deceased from May 12, 1951, to May 13, 1951, that I last saw the deceasedalive on May 13, 1951, and that death occurred at 10:45 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Paul B. Wilson M.D.Piedmont, W.Va.May 15, 1951

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/16/51</u>	NAME OF CEMETERY OR CREMATORY <u>Philos Cem.</u>	LOCATION (City, town, or county) <u>Westernport, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>May 16, 1951</u>	REGISTRAR'S SIGNATURE <u>Mr. Jean C. Kelly</u>	24. FUNERAL DIRECTOR <u>Ellsworth S. Boal</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

370916

RECEIVED
MAY 17 1951
BUREAU A. S.

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Westernport</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Westernport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>222 Philos Ave</u>		STREET ADDRESS <u>222 Philos Ave.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Melinda Susan Green</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>May 25 1951</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1/18/51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>4</u> yrs. If under 1 year: <u>4</u> Months <u>7</u> Days If under 24 hrs: <u>7</u> Hours <u>1</u> Min.
11. FATHER'S NAME <u>Ollie Green</u>		11. BIRTHPLACE (State or foreign country) <u>Keyser, W.Va.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>00</u>	14. MOTHER'S MAIDEN NAME <u>Nettie Dawson</u>
17. INFORMANT AND ADDRESS <u>Ollie Green</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>At Once</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>Acute Cardiac failure</u>		
Immediate cause (a) <u>776X</u>		
Antecedent cause(s) (b) <u>159</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) <u>Premature</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>H. V. Deming, M.D.</u> (Degree or title)		ADDRESS <u>Cumberland, Md.</u>	
DATE SIGNED <u>5/26/51</u>			
23. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/27/51</u>	NAME OF CEMETERY OR CREMATORY <u>Philos Cem.</u>	LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>
DATE REC'D BY LOCAL REG. <u>May 28, 1951</u>	REGISTRAR'S SIGNATURE <u>Miss Jean C. Kelly</u>	24. FUNERAL DIRECTOR <u>Ellsworth S. Boal, Westernport, Md.</u>	

20 1181 213293

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 29 1951
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04429

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH- COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Cumberland		CITY (If outside corporate limits, write RURAL and give nearest town) Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1218 Va. Ave.		STREET ADDRESS (If rural, give location) 1218 Va. Ave.	
3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Elva (Last) Harper		4. DATE OF DEATH (Month) May (Day) 2 (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 4-11-1875
9. AGE last birthday 76 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Winchester, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles H. Grim		14. MOTHER'S MAIDEN NAME Martha Ellen Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS James E. Harper Cumberland, Md.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Cerebral Hemorrhage			
Antecedent cause(s) (b) Arteriosclerosis			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Hypertension C-V Disease			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/1 , 19 51 , to 5/2 , 19 51 , that I last saw the deceased alive on 5/2 , 19 51 , and that death occurred at 5/2 m., from the causes and on the date stated above.			
SIGNATURE [Signature]		ADDRESS 404 Decatur DATE SIGNED 5/3/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 5-5-1951	
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		LOCATION (City, town, or county) Cumberland, Md. (State)	
DATE REC'D BY LOCAL REG. May 5, 1951		REGISTRAR'S SIGNATURE [Signature]	
24. FUNERAL DIRECTOR Charles L. George		ADDRESS Cumberland, Md.	

RECEIVED

MAY 10 1951

BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04430

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>ALLEGANY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CUMBERLAND</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CUMBERLAND</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>215 N. LEE STREET</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>FRANK</u>	(Middle) <u>A.</u>	(Last) <u>HITE</u>
4. DATE OF DEATH	(Month) <u>5</u>	(Day) <u>26</u>	(Year) <u>1951</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>2/6/1889</u>
9. AGE last birthday <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES T. HITE</u>		14. MOTHER'S MAIDEN NAME <u>EMMA YATES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>217-10-5979</u>	
17. INFORMANT AND ADDRESS <u>MEMORIAL HOSPITAL</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
181X Immediate cause (a) <u>Carcinoma of bladder</u>		7	
52b Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3-17-</u> 19 <u>51</u> , to <u>5-26-</u> 19 <u>51</u> , that I last saw the deceased alive on <u>5-24-</u> 19 <u>51</u> , and that death occurred at <u>3:25</u> P.m., from the causes and on the date stated above.			
SIGNATURE <u>Howard J. Tolson</u>		ADDRESS <u>M.D. Cumberland, Md.</u>	
DATE SIGNED <u>5-27-51</u>			
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>5-29-1951</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount Cem.</u>	
LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>			
DATE REC'D BY LOCAL REG. <u>May 29, 1951</u>		REGISTRAR'S SIGNATURE <u>Walter R. Hank, M.D.</u>	
24. FUNERAL DIRECTOR <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04431

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
TOWN <u>Cumberland</u> LENGTH OF STAY <u>all of life</u>		TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany Hospital</u>		STREET ADDRESS (If rural give location) <u>718 Lafayette Ave.</u>	
3. NAME OF DECEASED (First) <u>Mary</u> (Middle) <u>Bernadette</u> (Last) <u>Irons</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>3/12/1912</u>
9. AGE last birthday <u>39</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Silas Irons</u>		14. MOTHER'S MAIDEN NAME <u>Agnes E. Shields</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>214-05-6242</u>	
17. INFORMANT <u>James P. Irons</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Cardiac Failure

Antecedent cause(s)

(b)

Acute Hemorrhagic Pancreatitis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Coronary Sclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Atelectasis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

8 May 1951No significant findings

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 May, 1951, to 12 May, 1951, that I last saw the deceasedalive on 11 May, 1951, and that death occurred at 2:55 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

James P. Stegmaier M.D.122 So. Centre StCumberland Md12 May 51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 13, 1951Walter R. Sanz, M.D.James F. ScapelliCumberland Md

754679

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 23 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04432

CERTIFICATE OF DEATH

Reg. Dist. No. *4*

1. PLACE OF DEATH COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL		STREET ADDRESS (If rural, give location) 24 ARCH STREET	
3. NAME OF DECEASED (Type or Print)	(First) ALSTON	(Middle) G.	(Last) KESNER
4. DATE OF DEATH	(Month) MAY	(Day) 31	(Year) 1951
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 11/20/1894
9. AGE last birthday 56 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) taxi DRIVER		10b. KIND OF BUSINESS OR INDUSTRY ASTOR CAB CO.	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MOSES KESNER		14. MOTHER'S MAIDEN NAME MARTHA EMPSWILLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 213-18-2981	
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL- CUMBERLAND, MD.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Coronary occlusion</i>	<i>48 hrs</i>
Antecedent cause(s) (b) <i>Coronary Arteriosclerosis</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN)	(COUNTY)
(STATE)	
TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *May 21, 1951* to *May 31, 1951*, that I last saw the deceased alive on *May 31, 1951*, and that death occurred at *12:05 AM* from the causes and on the date stated above.

SIGNATURE *James F. Scarfelli* (Degree or title) ADDRESS *6/1/51* DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>6/2/51</i>	<i>Rose Hill Cem.</i>	<i>Cumberland</i>	<i>MD</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	M. FUNERAL DIRECTOR	ADDRESS	
<i>June 4, 1951</i>	<i>Walter R. Mandy, M.D.</i>	<i>James F. Scarfelli</i>	<i>Cumberland MD</i>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1952
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04433

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH - COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md</u> COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md</u>	
TOWN <u>Cumberland</u>		TOWN <u>Cumberland, Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>617 Brookfield Ave</u>		STREET ADDRESS (If rural, give location) <u>617 Brookfield Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Philip Raymond Kester</u>	(First) <u>Philip</u> (Middle) <u>Raymond</u> (Last) <u>Kester</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 24, 1906</u>
9. AGE last birthday <u>44</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Shickshinny, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>Shickshinny, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Raymond Kester</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Varker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Florence Kester, 617 Brookfield Ave.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Acute Coronary Occlusion</u>		
Antecedent cause(s) (b) <u>None</u>		
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>		
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF injury bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) _____ (COUNTY) _____ (STATE) _____
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 24, 1951</u>	INJURY OCCURRED While at <input type="checkbox"/> Not While at <input type="checkbox"/> Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from May 24, 1951, to May 24, 1951, that I last saw the deceased alive on May 23, 1951, and that death occurred at 11:30 P.m., from the causes and on the date stated above.

SIGNATURE W. Royce Hodges (Degree or title) ADDRESS Cumberland, Md. DATE SIGNED 5/26/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 27, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Elan Memorial Cemetery</u>	LOCATION (City, town, or county) <u>Luzerne Co., Pa.</u>
DATE REC'D BY LOCAL REG. <u>May 26, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Kestel, M.D.</u>	24. FUNERAL DIRECTOR <u>John J. Hager, Cumberland, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Dodge

RECEIVED
MAY 29 1954
BUREAU U. S.

Kuykendall

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04434

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY

Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Cumberland

LENGTH OF STAY (in this place)

22 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

924 Glenwood St.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Maryland

COUNTY

Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Cumberland

STREET ADDRESS

918 Glenwood St.

3. NAME OF DECEASED (Type or Print)

(First)

Nannie

(Middle)

L.

(Last)

Kuykendall

4. DATE OF DEATH

(Month)

May

(Day)

15

(Year)

1951

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Widowed

8. DATE OF BIRTH

7/17/1873

9. AGE last birthday

77

yrs.

10. UNDER 1 year

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Dry Goods

11. BIRTHPLACE (State or foreign country)

Moorefield West Virginia

12. CITIZEN OR WHAT

Citizen

13. FATHER'S NAME

Jacob Crites

14. MOTHER'S MAIDEN NAME

Sarah Mansfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

none

17. INFORMANT AND ADDRESS

Mr John Moore 924 Glenwood St

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

myocardial heart failure

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

6 weeks

2 years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes

No

X

21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work Not While At work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-3, 1949, to 5-15, 1951, that I last saw the deceased

alive on 5-13, 1951, and that death occurred at 5-15, 1951, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Wm M D

576 Greene St.

5-15-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 17, 1951

Walter R. Bantz, M.D.

James F. Scarfelli Cumberland MD

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 23 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04433

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and OR TOWN CUMBERLAND)		CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MAMORIAL HOSPITAL		STREET ADDRESS (If rural, give location) 204 HUMBIRD STREET	
3. NAME OF DECEASED (First) CHANCEY (Middle) L. (Last) LEWIS		4. DATE OF DEATH (Month) MAY (Day) 12 (Year) 1951	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 5/21/1888
9. AGE last birthday 62 yrs.		10. If under 1 year Months 12 Days 19 Hours 51 Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY BOAT	
11. BIRTHPLACE (State or foreign country) THORTON, W. VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN C. LEWIS		14. MOTHER'S MAIDEN NAME MARY ANNON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-05-1791	
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Myocardial Failure		4 days
Antecedent cause(s) (b) Chronic Myocarditis		4 yrs
(c) Arteriosclerosis		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Benign Hypertrophy of Prostate		
19a. DATE OF OPERATION 4/30/51	19b. MAJOR FINDINGS OF OPERATION Benign Hypertrophy	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT, SUICIDE, HOMICIDE (Specify) INJURY	PLACE (Home, farm, factory, street, office bldg., etc.) Cumberland Alleg. Md.	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan**, 19**48**, to **May 12**, 19**51**, that I last saw the deceased alive on **May 12**, 19**51**, and that death occurred at **10:10 P** m., from the causes and on the date stated above.

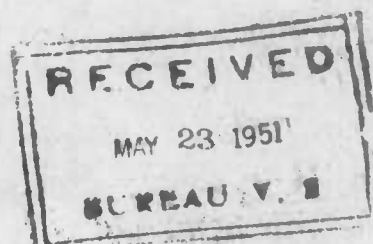
SIGNATURE **R. Williams M.D.** ADDRESS **Cumberland, Md.** DATE SIGNED **5/12/51**

23. BURIAL, CREMATION REMOVAL (Specify) **Burial** DATE THEREOF **May 15, 1951** NAME OF CEMETERY OR CREMATORY **Hillcrest Burial Park** LOCATION (City, town, or county) **Cumberland, Md.** (State)

DATE REC'D BY LOCAL REG. **May 15, 1951** REGISTRAR'S SIGNATURE **Walter R. Santz, M.D.** 24. FUNERAL DIRECTOR **John J. Hooper, Cumberland, Md.** ADDRESS **510246**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



DR. TOPPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04436

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>ALLEGANY</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CUMBERLAND</u> LENGTH OF STAY (in this place) <u>7 DAYS</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL CUMBERLAND, MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>PENNA.</u> COUNTY <u>Bedford</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HYNDMAN</u> STREET ADDRESS (If rural, give location) <u>RT. #1</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>IVY</u> <u>C</u> <u>LEYDIG</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May</u> <u>3</u> <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>8/5/1900</u>
9. AGE last birthday <u>50</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE SNOWDEN</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA SMITH</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>MEMORIAL HOSPITAL, CUMBERLAND, MD.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Carcinoma Left Breast</u>		
Antecedent cause(s) (b) <u>170X 50</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Jan 49</u> , 19 <u>49</u> , to <u>5/3/51</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 3 51</u> , 19 <u>51</u> , and that death occurred at <u>10:30 A.</u> m., from the causes and on the date stated above.		
SIGNATURE <u>John A. Topper</u> (Degree or title)		DATE SIGNED <u>May 3-1951</u> (State)
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 5 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Belcrest Cemetery</u>
LOCATION (City, town, or county) <u>Cumberland Md.</u>	24. FUNERAL DIRECTOR <u>Harvey N. Ziegler</u>	ADDRESS <u>Hyndman Pa.</u>
DATE REC'D BY LOCAL REG. <u>May 4, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Hantz, M.D.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 10 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04437

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>ALLEGANY</u> <u>CUMBERLAND</u> <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND, MD.</u> TOWN <u>CUMBERLAND, MD.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> <u>ALLEGANY</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG, Rural</u> TOWN <u>FROSTBURG, Rural</u> STREET ADDRESS (If rural, give location) <u>ROUTE # 1 BOX 316</u>	
3. NAME OF DECEASED (Type or Print) <u>KATHERINE</u> (First) <u>LOAR</u> (Last)		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>22</u> (Year) <u>51</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>AUG. 2, 1886</u>
9. AGE last birthday <u>64</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ISSAC MARTIN</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE ARTHUR</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>1-2-3-4-5-6-7-8-9-0</u>	
17. INFORMANT AND ADDRESS <u>MEMORIAL HOSPITAL</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause <u>442X</u> <u>131a</u> <u>Barrie Vasculer Panel</u>	(a) <u>Disease</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) <u>Disease</u>
		(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u> HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>
(CITY OR TOWN) <u></u> (COUNTY) <u></u> (STATE) <u></u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2-9, 1957, to 5-22, 1957, that I last saw the deceased alive on 5-21, 1957, and that death occurred at 5:20 a.m., from the causes and on the date stated above.

SIGNATURE W. F. Williams M.D. (Degree or title) ADDRESS Cumberland DATE SIGNED 5-22-57

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-24-57</u>	NAME OF CEMETERY OR CREMATORY <u>Valle Summit</u>	LOCATION (City, town, or county) <u>Valle Summit Md</u> (State) <u></u>
DATE REC'D BY LOCAL REG. <u>May 23, 1957</u>	REGISTRAR'S SIGNATURE <u>Walter L. Gandy, M.D.</u>	24. FUNERAL DIRECTOR <u>J. R. Dwyer</u>	ADDRESS <u>Frostburg Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 25 1954
BUREAU A. I.

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crimbsburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crimbsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany Hospital</u>		STREET ADDRESS <u>435 Grothe St</u> (Rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Bessie</u> (First) <u>Mae</u> (Middle) <u>Logan</u> (Last)		4. DATE OF DEATH <u>May 17</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 10 1907</u>
9. AGE last birthday <u>43</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>VA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Jacob Spousale</u>	14. MOTHER'S MAIDEN NAME <u>Sula Ketterman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY No. <u>none</u>	17. INFORMANT AND ADDRESS <u>Wm T Logan Crimbsburg Md</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(1)

LEADING TO DEATH
Cancer of uterus (cervix)

INTERVAL BETWEEN ONSET AND DEATH

1240

Antecedent cause(s)

(b)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
------------------------	----------------------------------

20. AUTOPSY?

Yes ☐ No ☐

Yes ☐ No ☐
(STATE)

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
-------------------------------------	-----------	---

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF
INJURY

INJURY OCCURRED	
While at Work	Not While At work
<input type="checkbox"/>	<input type="checkbox"/>

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1st, 1950, to May 17, 1951, that I last saw the deceased

alive on Apr 23, 1957, and that death occurred at 8:30 a m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**23. BURIAL, CREMATION
REMOVAL (Specify)**

DATE THEREOF _____

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

4
(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

REG. ^{ADDRESS}
May 19, 1951 White R. Gantz M.D. William F. Knight Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04439

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u> LENGTH OF STAY (In this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>531 Fort Ave</u>		STREET ADDRESS (If rural, give location) <u>531 Fort Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Henry</u>	(Middle) <u>Raymond</u>	(Last) <u>Long</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>6</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>June 29-1881</u>
9. AGE last birthday <u>69</u> yrs.	If under 1 year Months <u></u> Days <u></u>	If under 24 hrs Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O R.Ry</u>	11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Harrison Long</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Mc Mahan</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>Spanish W.</u>	
16. SOCIAL SECURITY No. <u>705-05-5198</u>		17. INFORMANT AND ADDRESS <u>Mary E. Clise, 531 Fort Ave.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Acute cardiac failure due to</u>		<u>at once</u>
(b) Antecedent cause(s) <u>Cardiac degeneration</u>		<u>2 yrs</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE (Degree or title) <u>H. V. Deming M.D.</u>		DATE SIGNED <u>May 6-1951</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 9 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cem.</u>
LOCATION (City, town, or county) <u>Cumberland</u>	STATE <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>May 7, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Hantz, M.D.</u>	24. FUNERAL DIRECTOR <u>Louis Stein Inc. Cumberland Md.</u>

533506

RECEIVED
MAY 15 1951
BUREAU 7. 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04440

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany County Infirmary</u>		STREET ADDRESS (If rural, give location) <u>202 Baltimore Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Edward</u> (First) <u>Thomas</u> (Middle) <u>Lyons</u> (Last)		4. DATE OF DEATH 5 21 1957 (Month) (Day) (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>11/01/1895</u> <u>56</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>61</u> yrs.	
13. FATHER'S NAME <u>Jacob Lyons</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Ross</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Don Lyons, Brooking Md</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Congestive Heart Failure</u>		<u>1 wk</u>	
Antecedent cause(s) (b) <u>Chr. Myocarditis</u>		<u>6 Mo</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR? Injury occurred While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Oct. 6</u> , 19 <u>50</u> , to <u>May 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 24</u> , 19 <u>57</u> , and that death occurred at <u>10:40 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Arthur T. Jones M.D.</u>		DATE SIGNED <u>May 25, 1957</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/31/57</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Marys Cem</u>		LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
DATE REC'D BY LOCAL REG. <u>May 28, 1957</u>		FUNDAL DIRECTOR ADDRESS <u>William H. Wright Cumberland Md</u>	

RECEIVED
JUN 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

04441

1. PLACE OF DEATH- COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN nr. McCoole		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN nr. McCoole	
HOSPITAL OR INSTITUTION OR STREET ADDRESS rt. 3 Keyser, V. Va.		STREET ADDRESS (If rural, give location) rt. 3 Keyser, W. Va.	
3. NAME OF DECEASED (Type or Print) Pauline		4. DATE OF DEATH (Month) May (Day) 25 (Year) 19 51	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 11/2/1886
9. AGE last birthday 64 yrs.		10. If under 1 year Months 6 Days 25 If under 24 hrs. Hours 25 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Rocco Casale, Italy		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Conzio Scarpone		14. MOTHER'S MAIDEN NAME Marie Zizzinio	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Antonio Mastrodominico			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **Carcinoma left ovary - Generalized ascietis**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Generalized carcinomatosis**

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from....., 19.46., to **May. 25...., 1951..**, that I last saw the deceasedalive on **May 25**, 19 **51**, and that death occurred at **12:30 p.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

M.D.

Keyser, W. Va.

5/26/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 5/28/51	NAME OF CEMETERY OR CREMATORY St. Thomas	LOCATION (City, town, or county) Keyser, W. Va.	(State)
DATE REC'D BY LOCAL REG. 5/28/51	REGISTRAR'S SIGNATURE Mrs. Jean C. Kelly	24. FUNERAL DIRECTOR Rogers Funeral Home, Keyser, W. Va.	ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04442

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Nikep</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Nikep</u>	
TOWN <u>Nikep</u>		TOWN <u>Nikep</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>None</u> (If rural, give location)	
3. NAME OF DECEASED (First) <u>Viola</u> (Middle) <u>Matthews</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>30</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 6, 1875</u> 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>76</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Bothwell</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>David Matthews</u>		<u>Nikep Md</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>myocarditis</u>			<u>2 wks</u>
Antecedent cause(s) (b) <u>Bronchitis</u>			<u>2 wks</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>arteriosclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 15, 1951</u> , to <u>May 30, 1951</u> , that I last saw the deceased alive on <u>May 30, 1951</u> , and that death occurred at <u>8 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>P. Berry</u>		ADDRESS <u>m.d. Piedmont W Va</u> DATE SIGNED <u>6/2/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>June 3, 1951</u>	<u>Laurel Hill Cemetery</u>	<u>Moscow MD</u>
DATE FILED BY LOCAL REG <u>6-2-51</u>	REGISTRAR'S SIGNATURE <u>Jannette M. Fra</u>	24. FUNERAL DIRECTOR <u>M. Eichhorn</u> ADDRESS <u>Lonaconing MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 13 1951
BUREAU V. S.

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

04443

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH - COUNTY <u>ALLEGANY</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND, MD.</u> OR TOWN <u>CUMBERLAND, MD.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL CUMBERLAND, MD.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>MIDLAND, MARYLAND</u> OR TOWN <u>MIDLAND, MARYLAND</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Baby Girl Lisa</u>	(First) (Middle) (Last) <u>McGOWAN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 8 1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>None</u>	8. DATE OF BIRTH <u>MAY 8 1951</u>
9. AGE last birthday <u>1</u> yrs. <u>1</u> month <u>16</u> days		10. BIRTHPLACE (State or foreign country) <u>CUMBERLAND, MARYLAND</u>	
11. FATHER'S NAME <u>MICHAEL D. McGOWAN</u>		12. MOTHER'S MAIDEN NAME <u>HILDA B. GRAY</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		14. SOCIAL SECURITY NO. <u>None</u>	
15. INFORMANT AND ADDRESS <u>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</u>		16. CITIZEN OF WHAT COUNTRY <u>USA</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) <u>CUMBERLAND</u>	(COUNTY) <u>MARYLAND</u>	(STATE) <u>MARYLAND</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 8 1951</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Probable aspiration of fluid.</u>		

22. I hereby certify that I attended the deceased from May 8, 1951, to May 8, 1951, that I last saw the deceasedalive on May 8, 1951, and that death occurred at 9:30 a.m., from the causes and on the date stated above.SIGNATURE W. R. Oye Hodges, M.D. (Degree or title) ADDRESS Cumberland, Md. DATE SIGNED 5/8/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 8, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St Michael Cemetery</u>	LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>
DATE REC'D BY LOCAL REG. <u>May 8, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Roney, Jr.</u>	24. FUNERAL DIRECTOR <u>M. Eichhorn, Lonsdale, Md.</u>	

205001 321404

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 15 1961
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04444

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH - COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany County Infirmary</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Annie</u> (Middle) <u>Reid</u> (Last) <u>McIndoe</u>	4. DATE OF DEATH	(Month) <u>5</u> (Day) <u>16</u> (Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>Jan. 19, 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR OCCUPATION <u>Own home</u>	9. AGE last birthday <u>83</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Lonaconing Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Reid</u>		14. MOTHER'S MAIDEN NAME <u>Anne Cummings</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs Frank Thompson</u>		<u>Baltimore, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial failure
 Antecedent cause(s) (b) Coronary sclerosis
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

2 days
10 hrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan. 8, 1951, to May 16, 1951, that I last saw the deceased alive on May 16, 1951, and that death occurred at 11 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 19, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	LOCATION (City, town, or county) <u>Lonaconing Md</u>
DATE REC'D BY LOCAL REG. <u>May 18, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Jones, M.D.</u>	24. FUNERAL DIRECTOR <u>M. Eichhorn</u>	ADDRESS <u>Lonaconing Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 23 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04445

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland (<i>Transient</i>)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Co. Infirmary		STREET ADDRESS (If rural, give location) Allegany Co. Home	
3. NAME OF DECEASED (Type or Print) Nimrod (First) (Middle) (Last) Mellott		4. DATE OF DEATH (Month) (Day) (Year) May 24, 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 12-15-1868
9. AGE last birthday 82 yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10. b. KIND OF BUSINESS OR INDUSTRY Laborer
11. BIRTHPLACE (State or foreign country) Fulton Co. Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Isaac Mellott		14. MOTHER'S MAIDEN NAME Rachael ----- ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Alleg. Co. Home Cumberland, Md.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592X Immediate cause (a)
Antecedent cause(s) (b)
131 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

Uremic Poison
Chronic Nephritis

INTERVAL BETWEEN ONSET AND DEATH

3 wks
8 mos

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *Dec 4, 1946* to *May 24, 1951*, that I last saw the deceased alive on *May 24, 1951*, and that death occurred at *4:30 p.m.* from the causes and on the date stated above.

SIGNATURE *Arthur F. Jones* (Degree or title) ADDRESS *72. E. 110 S. Centre St.* DATE SIGNED *May 24, 1951*

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	5-27-1951	Green Hill Cem.	Waynesboro, Penna.	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>May 24, 1951</i>	<i>Walter R. Hart, M.D.</i>	Charles L. George	Cumberland, Md.

970000

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 29 1951
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04446

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>605 Louisiana Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> TOWN STREET ADDRESS <u>605 Louisiana Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Elizabeth</u> (Middle) <u>Kreider</u> (Last) <u>Miley</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>26</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 16, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	9. AGE last birthday (If under 1 year) <u>59</u> yrs. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Lancaster Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Franklin D. Miley</u>		14. MOTHER'S MAIDEN NAME <u>Maude Schaubel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Miss Mabel S. Miley</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Carcinoma of Breast (b) Ovary

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>7.7.50</u>		19b. MAJOR FINDINGS OF OPERATION <u>Extensive sloughing of left breast</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Extensive sloughing of left breast</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Cumberland</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7.4.50</u>		INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 7.4.50, 1950, to 5.26.51, 1951, that I last saw the deceased alive on 5.25.51, 1951, and that death occurred at 7:59 m., from the causes and on the date stated above.

SIGNATURE Dr. J. Williams M.D.

(Degree or title)

ADDRESS CumberlandDATE SIGNED 5-26-51

23. BURIAL, CREMATION (Removal) (Specify) <u>Burial</u>		DATE THEREOF <u>May 29, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Green Wood Cem.</u>		LOCATION (City, town, or county) <u>Lancaster Penna.</u>		(State)	
DATE REC'D BY LOCAL REG. <u>May 27, 1951</u>		REGISTRAR'S SIGNATURE <u>Walter L. Smith, M.D.</u>		24. FUNERAL DIRECTOR <u>Louis Stein Inc.</u>		ADDRESS <u>093 Cumberland, Maryland</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 4 1951
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE PENNA Somerset	
CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		CITY (If outside corporate limits, write RURAL and give nearest town) FAIRHOPE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL		STREET ADDRESS (If rural, give location) ROUTE #1	
3. NAME OF DECEASED (Type or Print) HARRY	(First) B (Middle)	(Last) MOWERY	4. DATE OF DEATH MAY 16 1951
6. SEX MALE	8. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH MAY 1, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	9. AGE last birthday 68 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME LEWIS W. MOWERY		11. BIRTHPLACE (State or foreign country) PENNA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		14. MOTHER'S MAIDEN NAME MARGARET V. LAFFERTY	
16. SOCIAL SECURITY No. 176-16-1639		17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) acute Cardiac Dilatation	Antecedent cause(s) (b) Sub total Gastrectomy	
	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Massive duodenal ulcer	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Penetrating		
19. DATE OF OPERATION May 16	19b. MAJOR FINDINGS OF OPERATION Massive penetrating ulcer of 9th duodenum	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
19a. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **May 6, 1951**, to **May 6, 1951**, that I last saw the deceased alive on **May 15, 1951**, and that death occurred at **6:55 A.M.** from the cause and on the date stated above.

SIGNATURE **A. D. Insigard** ADDRESS **Cumberland** DATE SIGNED **5/17/51**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 5/19/51	NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery	LOCATION (City, town, or county) Fairhope RD Somerset Pa
DATE REC'D BY LOCAL REG. May 16, 1951	REGISTRAR'S SIGNATURE Wm. R. Hark	24. FUNERAL DIRECTOR W. A. Johnson	ADDRESS Berlin Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 23 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04448

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL		STREET ADDRESS ROUTE #3 MASON ROAD	
3. NAME OF DECEASED (Type or Print) LINDA Diane NEALIS		4. DATE OF DEATH (Month) MAY (Day) 3 (Year) 1951	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH SEPT. 23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, evoo if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday yrs. 11 Moths 11 Days 11 Hours 11 Mins.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME HARRY E. NEALIS		14. MOTHER'S MAIDEN NAME LILLIAN V. STEVENS	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____	
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Bilateral Lobar Pneumonia (Virus)

Trocheo Bronchitis Virus

INTERVAL BETWEEN ONSET AND DEATH

4 days

4 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **5-3-51**, 19**51**, to **5-3-51**, 19**51**, that I last saw the deceased

alive on **5-3-51**, 19**51**, and that death occurred at **11:42 P.M.**, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL, (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	May 5, 1951	Ft. Ashby Cemetery	Ft. Ashby	W. Va.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
May 5, 1951	Walter R. Zantz, M.D.	John J. Hager, Cumberland, Md.		

209230334404

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAY 10 1951

BUREAU V. S.

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04449

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegheny Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Pennsylvania</u> COUNTY <u>Northumberland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Northumberland, rural</u> LENGTH OF STAY (in this place) <u>6 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Northumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. L. Roberts Place, Bowling Green</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print) <u>Elizabeth</u> (First) <u>Oswald</u> (Middle) <u>Osward</u> (Last)		4. DATE OF DEATH <u>May</u> (Month) <u>31</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 17, 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>84</u> yrs. <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>
13. FATHER'S NAME <u>Sylvester Hanly</u>		14. MOTHER'S MAIDEN NAME <u>Eudora Woodin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>W.H. Oswald - Cumberland Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Myocardial Failure</u>	<u>6 hours</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Chronic Myocarditis</u>	<u>10 yrs.</u>
	(c) <u>Coronary Artery disease</u>	<u>10 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-31, 1951 to 5-31, 1951, that I last saw the deceased alive on 5-31, 1951, and that death occurred at 6 A m., from the causes and on the date stated above.

SIGNATURE <u>Alfred Carson M.D.</u>	ADDRESS <u>126 Quince St. Cumberland Md</u>	DATE SIGNED <u>5/31/51</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 2, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cem. Berwick Pa.</u>
24. REC'D BY LOCAL REG. <u>May 31, 1951</u>	REGISTRAR'S SIGNATURE <u>Printer R. Santz, M.D.</u>	24. FUNERAL DIRECTOR <u>Louis & Stein Inc. Cumberland, Maryland</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1951
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04450

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland LENGTH OF STAY (In this place) 50 Yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 518 Cumberland St.		STREET ADDRESS (If rural, give location) 518 Cumberland, St.	
3. NAME OF DECEASED (First) James (Middle) Emory (Last) Perrin		4. DATE OF DEATH (Month) May (Day) 17 (Year) 1951	
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Sept. 25-1872
9. AGE last birthday 78 yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor	
10b. KIND OF BUSINESS OR INDUSTRY Realtor		11. BIRTHPLACE (State or foreign country) near, Flintstone, Md.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Dennis A. Perrin	
14. MOTHER'S MAIDEN NAME Hulda Wilson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY No. none		17. INFORMANT AND ADDRESS Mrs. James Perrin, Cumberland, Md.	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
450.0 Immediate cause (a) Arteriosclerosis		?
97 Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death. Rheumatoid arthritis		25 yrs.
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
		HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H.V. Deming M.D. <i>H.V. Deming M.D.</i> Cumberland, Md.		May 18-1951	
23. BURIAL CREMATION RITUAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Funeral	5-19-1951	Rose Hill Mausoleum	Cumberland, Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 18, 1951	Walter R. Kirby, M.D.	Charles L. George	Cumberland, Md.

470746

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04451

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Spring Gap</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegheny Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Lionel Montgomery Piper</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>21</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Apr. 12, 1877</u>
9. AGE last birthday <u>74</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Oldtown, Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Piper</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Wagoner</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Etta Piper, Spring Gap, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

Sudden

Antecedent cause(s)

(b)

Scurvitic scurvy3 m

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 15, 1951, to May 21, 1951, that I last saw the deceased alive on May 21, 1951, and that death occurred at 8 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Clay J. LunsfordCumberland5/23/51

23. BURIAL, CREMATION REMOVAL, (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 24, 1951</u>	<u>Davis Memorial Cemetery</u>	<u>Allegheny Co.</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS
<u>May 24, 1951</u>	<u>Walter L. Kartz, M.D.</u>	<u>John J. Hoyer, Cumberland, Md.</u>		<u>510246</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Bennett

RECEIVED
MAY 29 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chamberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Shaft</u>	
TOWN <u>Chamberland</u>		TOWN <u>Shaft</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany Hosp.</u>		STREET ADDRESS (If rural, give location) <u>Rt. 2, Box 134</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles</u>	(Middle) <u>Franklin</u>	(Last) <u>Plummer</u>
4. DATE OF DEATH	(Month) <u>5</u>	(Day) <u>6</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 24, 1894</u>
9. AGE last birthday <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Press Tinner</u>	
11. FATHER'S NAME <u>David H. Plummer</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. MOTHER'S MARRIAGE <u>Seaton</u>		14. MOTHER'S MARRIAGE <u>Seaton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMATION AND ADDRESS <u>Rt. 2, Box 134</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cardiac dilatation (R heart failure)</u>		<u>3 hrs. 20'</u>
Antecedent cause(s) (b) <u>Median bar - urinary bladder</u>		<u>6 mos ±</u>
Dissecting Aneurysm - lower aorta (c) <u>Hydrops of Gall-bladder</u>		<u>26 hrs.</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <u>No</u>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/10, 1951, to 5/6, 1951, that I last saw the deceased alive on 5/6, 1951, and that death occurred at 1:20 A.M., from the causes and on the date stated above.

SIGNATURE Frank J. Harriet M.D. ADDRESS 59 E. Main St. Frostburg, Md. DATE SIGNED 5/7/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 5-8-51 NAME OF CEMETERY OR CREMATORY Frostburg Park LOCATION (City, town, or county) Frostburg, Md.

DATE REC'D BY LOCAL REG. May 8, 1951 REGISTRAR'S SIGNATURE Walter R. Dantz, M.D. FUNERAL DIRECTOR Jacob D. Dantz, Frostburg, Md. ADDRESS

MAY 15 1961
BUREAU A.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04453

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>West Virginia</u> COUNTY <u>Mineral</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kidgley</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany Hospital</u>		STREET ADDRESS (If rural give location) <u>2 Potomac Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>W.</u>	(Last) <u>Reed</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>24</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 7, 1886</u>
9. AGE last birthday <u>64</u> yrs		10. AGE last birthday <u>64</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor on trains</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D. M. R. R. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Shaw West Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Daniel Reed</u>		14. MOTHER'S MAIDEN NAME <u>Marion Barker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>705-10-8515</u>	
17. INFORMANT <u>Mrs. Lillie M. Reed, Kidgley, W. Va.</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Myocardial Failure</u>	<u>2 weeks</u>
Antecedent cause(s) (b) <u>Hypertrophy + Dilatation of Heart</u>	<u>3 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Rheumatic Heart Disease</u>	<u>?</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Inactive Aortic Valvulitis</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Aortic Stenosis</u>
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 50, to May 24, 1951, that I last saw the deceased alive on May 27, 1951, and that death occurred at 2:45 A.M., from the causes and on the date stated above.

SIGNATURE Charles O. Weisman M.D. ADDRESS 59 Green St Cumberland, Md. DATE SIGNED May 25, 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>May 26, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Cumberland</u>	(State) <u>Maryland</u>
DATE REC'D BY LOCAL REG. <u>May 25, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Dargatzis, M.D.</u>	24. FUNERAL DIRECTOR <u>Charles L. George</u>	ADDRESS <u>Cumberland, Md.</u>	

203506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr Weckman

BUREAU U. S.

MAY 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04454

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital		STREET ADDRESS (If rural, give location) Jackson Street	
3. NAME OF DECEASED (Type or Print)	(First) Oscar (Middle)	(Last) Richardson	4. DATE OF DEATH (Month) (Day) (Year) May 20 19 51
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 4, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	9. AGE last birthday 63 yrs. If under 1 year Months Days Hours Mln.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. Richardson		14. MOTHER'S MAIDEN NAME Ida Huff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY No. none	
17. INFORMANT Robert Richardson			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Hypertensive Cardio Vascular		
Antecedent cause(s) (b) Renal disease		4 mo.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
NONE		
21. ACCIDENT (Specify) NONE	PLACE (Home, farm, factory, street, OF office bldg., etc.) NONE	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY None	INJURY OCCURRED White at Work <input type="checkbox"/> Not White At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb**, 19**51**, to **5/20**, 19**51**, that I last saw the deceased alive on **5/20**, 19**51**, and that death occurred at **3:30 P. m.**, from the causes and on the date stated above.

SIGNATURE Paul Eugene Dwyer M.D.	ADDRESS Lonaconing Md	DATE SIGNED 5/22/51
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF May 23, 1951	NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery
LOCATION (City, town, or county) Lonaconing	(State) Md	
DATE REC'D BY LOCAL REG. 5-24-51	REGISTRAR'S SIGNATURE Wm. Harvey A. Roe	24. FUNERAL DIRECTOR M. Eichhorn
		ADDRESS Lonaconing, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 28 1951
BUREAU V.I.S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04455

Reg. Dist. No. 1

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>W.Va.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural, route 51</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hedgesville</u>	
TOWN <u>Cumberland</u> LENGTH OF STAY <u>at once</u>		TOWN <u>Hedgesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>about 1/4 north of Pickard</u> Md		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Moses</u>	(Middle) <u>Allen</u>	(Last) <u>Robbins</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>17</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 27-1895</u>
9. AGE last birthday <u>55</u> yrs.	If under 1 year Months	If under 24 hrs Days	If under 24 hrs Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mgr. Sales & Service for Farm Supplies</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Beckley Co. W.Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Conrad Robbins</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Mae Nadendousch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Wife) Edith Ward Robbins. Hedgesville</u>		<u>W.Va.</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Pulmonary hemorrhage due to punctured lung</u>	<u>at once</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>(left side) from fractured ribs, also asphyxia.</u>	
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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21. EXTERNAL CAUSE WAS PRIMARY * OR CONTRIBUTING CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Rural, route 51 near Pickard, Md.</u>	(CITY OR TOWN) <u>Cumberland</u>	(COUNTY) <u>Allegany</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) <u>May 17/51 P. 3.38</u>	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Truck lost control descending grade, ran into a parked truck. he was thrown out of truck.</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ the result and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>H.V. Deming M.D.</u>	ADDRESS <u>Cumberland, Md.</u>	DATE SIGNED <u>May 18-1951</u>
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23. BURIAL, CREMATION (Specify)	DATE THEREOF <u>May 20-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Hedgesville Cemetery</u>	LOCATION (City, town, or county) <u>Hedgesville, West Va.</u>	(State)
DATE REC'D BY LOCAL REG. <u>May 18, 1951</u>	REGISTRAR'S SIGNATURE <u>Mrs. Luc C. Ginevan</u>	24. FUNERAL DIRECTOR <u>Charles L. George</u>	ADDRESS <u>Cumberland, Md.</u>	

290 -698

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 22 1951
BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04456

Reg. Dist. No. 1

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Old Town</u> TOWN <u>Old Town</u> rural, near <u>2 yrs</u> LENGTH OF STAY (in this place)				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Old Town, Md.</u> TOWN <u>Rural, near Old Town, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>***D** Route 51</u>				STREET ADDRESS (If rural, give location) <u>Route 51</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>Chester</u>		(Middle) <u>Lewis</u>		(Last) <u>Robertson</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widower</u>		8. DATE OF BIRTH <u>Dec 10-1893</u>	
9. AGE last birthday <u>57</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>odd jobs</u>		11. BIRTHPLACE (State or foreign country) <u>Green Ridge, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Enos Alexander Robertson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Virginia Keefer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>705-12-6952</u>		17. INFORMANT AND ADDRESS <u>Mrs Clyde Crabtree, Old Town, Md.</u>			

18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute Cardiac failure</u>					<u>at once</u>
Antecedent cause(s) (b) <u>Chronic myocarditis</u>					<u>?</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
SIGNATURE <u>H.V. Deming M.D.</u>				DATE SIGNED <u>May 21-1951</u>	
(Degree or title)				ADDRESS <u>Cumberland, Md.</u>	
23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>		DATE THEREOF <u>May 23, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Oldtown Methodist Cemetery</u>	
LOCATION (City, town, or county) <u>Oldtown, Md.</u>		(State)			
DATE REC'D BY LOCAL REG <u>May 23-1951</u>		REGISTRAR'S SIGNATURE <u>Arce. Luc C. Linwan</u>		24. FUNERAL DIRECTOR <u>Phil J. Hofer, Cumberland, Md.</u>	
ADDRESS					

9700VV

MARGIN RESERVED FOR BINDING

VS. A15A

RECEIVED
MAY 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

04457

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Westernport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wood St.</u>		STREET ADDRESS (If rural, give location) <u>Wood St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>GEORGE</u>	(Middle) <u>HENRY</u>	(Last) <u>ROBERTSON Sr.</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	4. DATE OF DEATH <u>May 8 1951</u>
8. DATE OF BIRTH <u>Aug. 28, 1876</u>	9. AGE last birthday <u>74 yrs.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter - self</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	13. FATHER'S NAME <u>George H. Robertson</u>	
14. MOTHER'S MAIDEN NAME <u>Jean Riggins</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Goerge H. Robertson Jr., Westernport</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Embolus
Chronic Myocarditis and Myocardial Degeneration

INTERVAL BETWEEN ONSET AND DEATH

6 HoursAntecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(b) Not Specified As Rheumatic3 MonthsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

NoneNone

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 25, 1951, to May 7, 1951, that I last saw the deceasedalive on May 7, 1951, and that death occurred at 6:15 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) Burial DATE THEREOF May 10, 1951 NAME OF CEMETERY OR CREMATORY Philos Cem. LOCATION (City, town, or county) Westernport (State) MarylandDATE REC'D BY LOCAL REG. May 10, 1951 REGISTRAR'S SIGNATURE Mrs. Jean C. Kelly

24. FUNERAL DIRECTOR

ADDRESS

E.S. Boal 111 Church St. 574246
Westernport, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 14 1951
BUREAU W. S.

Within 48 hours of death

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04458

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE W. Va. COUNTY Mineral	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Ridgeley	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital		STREET ADDRESS (If rural, give location) Near Route # 28	
3. NAME OF DECEASED (Type or Print) (First) Alice (Middle) Mae (Last) Rose		4. DATE OF DEATH (Month) May (Day) 18 (Year) 19 51	
5. SEX female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6-21-1902
9. AGE last birthday 48 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Mineral Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Enoch Umstot		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Mr. George L. Rose Ridgeley, W. Va.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause Cancer of the sigmoid		6 months
(b) Antecedent cause(s) metastatic cancer of the liver		6 months
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5-1-1957**, to **5-18-1957**, that I last saw the deceased alive on **5-18-1957**, and that death occurred at **1007 A** m., from the causes and on the date stated above.

SIGNATURE **L. M. M. M.D.** ADDRESS **570 Greene St.** DATE SIGNED **5-19-57**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 5-21-1951	NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. May 19, 1951	REGISTRAR'S SIGNATURE Walter R. Hantz, M.D.	24. FUNERAL DIRECTOR Charles L. George	ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr L. Brings



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04459

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Barton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Barton, 1 1/2 miles South</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Barton</u>		STREET ADDRESS (If rural, give location) <u>1 1/2 Miles South of Barton</u>	
3. NAME OF DECEASED (First) <u>Agnes</u> (Middle) <u>Russell</u> (Last) <u>Russell</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>13</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 27, 1893</u> 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own-Home</u>	9. AGE last birthday <u>57</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Bradley</u>		14. MOTHER'S MAIDEN NAME <u>Martha Majimsey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>XXXXX</u>	
17. INFORMANT AND ADDRESS <u>Floyd R. Russell-- Barton, Maryland</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

8 Hours

Antecedent cause(s)

(b)

HypertensionUnknown

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT (Specify) None PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 12, 1951, to May 13, 1951, that I last saw the deceasedalive on May 12, 1951, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Paul B. WilsonM.D.Piedmont, W. Va.May 15, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/15/51</u>	NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cem.</u>	LOCATION (City, town, or county) <u>Moscow</u> (State) <u>Maryland</u>
DATE REC'D BY LOCAL REG. <u>5-15-51</u>	REGISTRAR'S SIGNATURE <u>Miss Jane C. Kelly</u>	24. FUNERAL DIRECTOR <u>E.S. Boal</u>	ADDRESS <u>111 Church St. Westernport, Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04460

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>21 W. First St.</u>		STREET ADDRESS (If rural, give location) <u>21 W. First Street.</u>	
3. NAME OF DECEASED (First) <u>Nonnie</u> (Middle) <u>Beaty</u> (Last) <u>Short</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>23</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 22, 1873</u> 27 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Fort Ashby, W. Va.</u>
13. FATHER'S NAME <u>Jacob A. Marker</u>		14. MOTHER'S MAIDEN NAME <u>Minerva</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Miss Margaret Short 21 W. 1st St.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>46 coronary sclerosis</u>		<u>6 wks</u>
Antecedent cause(s) (b) <u>myocarditis</u>		<u>2 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950 to May 23, 1951, that I last saw the deceased alive on May 23, 1951, and that death occurred at m., from the causes and on the date stated above.

SIGNATURE Clayton J. Jowers (Degree or title) ADDRESS Cumberland DATE SIGNED 5/24/51

23. BURIAL, CREMATION REINTERMENT (Specify) <u>Burial</u>	DATE THEREOF <u>May 26, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Fort Ashby Cem</u>	LOCATION (City, town, or county) (State) <u>Fort Ashby, W. Va.</u>
DATE REC'D BY LOCAL REG. <u>May 26, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter K. Vandy, M.D.</u>	24. FUNERAL DIRECTOR <u>John J. Hafer, Cumberland, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. W. Barrett

BUREAU V. S.

MAY 29 1931

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
TOWN <u>Frostburg</u>		TOWN <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>118 Bowery St.</u>		STREET ADDRESS (If rural, give location) <u>118 Bowery St.</u>	
3. NAME OF DECEASED (First) <u>ANNA</u> (Middle) <u>(DONAHUE)</u> (Last) <u>SMELTZ</u>		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>11-10-1886</u>
9. AGE last birthday <u>64</u> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Donahue</u>		14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Leroy Smeltz, Frostburg, Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>5 mo.</u>
Immediate cause (a) <u>Thyroid heart disease</u>		
252. Antecedent cause(s) (b) <u>Toxic adenoma thyroid</u>		5 yrs.
63b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 28, 1951, to 5/10, 1951, that I last saw the deceased alive on 5/9, 1951, and that death occurred at 4:00 p.m., from the causes and on the date stated above.

SIGNATURE W. E. Gattens (Degree or title) M.D. ADDRESS Frostburg Md. DATE SIGNED 5/11/51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE 5-12-1951 NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REG. 5-12-51 REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe 24. FUNERAL DIRECTOR J. R. Durst ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 15 1961
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04462

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegheny-</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>ALLEGHANY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND,</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND, M.D.</u>	
TOWN <u>CUMBERLAND,</u>		TOWN <u>CUMBERLAND, M.D.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>121 VIRGINIA AVE</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>LORETTA</u>	(Middle) <u>VIRGINIA</u>	(Last) <u>STUCK</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>OCTOBER 7, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>63</u> yrs.
13. FATHER'S NAME <u>JAMES M. PHILLIPS</u>		11. BIRTHPLACE (State or foreign country) <u>INDEPENDENCE, W.Va</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
16. SOCIAL SECURITY No. <u>None</u>		14. MOTHER'S MAIDEN NAME <u>Cardelia PIERCE</u>	
17. INFORMANT AND ADDRESS <u>JAMES R STUCK Sr. 121 Virginia Ave</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Myocardial Failure</u>	<u>48 hrs</u>
175X Antecedent cause(s)	(b) <u>C. of Prostate C Metastasis</u>	<u>1 yr</u>
49 a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Myocardial Stenosis</u>	<u>?</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Gauntness</u>		<u>1 month</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Cumberland Alley Md</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/20/51, 19....., to 5/18/51, 19....., that I last saw the deceased alive on 5/18/51, 19..... and that death occurred at.....m. from the causes and on the date stated above.

SIGNATURE <u>J. Phillips</u>	ADDRESS <u>Cumberland Md</u>	DATE SIGNED <u>5/19/51</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/21/51</u>	NAME OF CEMETERY OR CREMATORY <u>Knight of P. & B. Cem</u>
LOCATION (City, town, or county) <u>Newberg, W.Va.</u>	(State) <u>W.Va.</u>	
DATE REC'D BY LOCAL REG. <u>May 19, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter K. Rantz, M.D.</u>	24. FUNERAL DIRECTOR <u>James F. Scarpelli</u>
		ADDRESS <u>Cumberland W.Va.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr. C. J. Hines



MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04463

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>106 N.Mechanic St.</u>		STREET ADDRESS (If rural, give location) <u>106 N.Mechanic St.</u>	
3. NAME OF DECEASED (First) <u>Archie</u> (Middle) (Last) <u>Taylor</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>12/24/89</u>
9. AGE last birthday <u>62</u> yrs. If under 1 year Months <u>2</u> Days <u>20</u>		10. BIRTHPLACE (State or foreign country) <u>NY</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sign painter</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Faggens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no known</u>		16. SOCIAL SECURITY No. <u>papers in pocket</u>	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>	<u>at once</u>
Antecedent cause(s) (b) <u>Coronary sclerosis</u>	<u>?</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>H.V. Deming M.D.</u> (Degree or title)		DATE SIGNED <u>May 21-1951</u>	
ADDRESS <u>Cumberland, Md.</u>			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 24, 1951</u>	<u>Woodlawn Cemetery</u>	<u>Cumberland Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>May 24, 1951</u>	<u>Frank R. Hanz, M.D.</u>	<u>Louis Stuenkel, Inc.</u> <u>Cumberland, Maryland 564808</u>	

BUREAU V. S.

MAY 29 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04464

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH - COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany County Infirmary</u>		STREET ADDRESS <u>617 Elm St.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Henry</u>	(Middle) <u>E</u>	(Last) <u>Topp</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>1-15-63</u>
9. AGE last birthday <u>88</u> yrs.		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>29</u> (Year) <u>1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Odd jobs</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Lewis Topp</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. MOTHER'S MAIDEN NAME <u>Ellen Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Grace P. Groves 617 Elm St</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Myocardial failure</u>			<u>10 days</u>
Antecedent cause(s) (b) <u>Coronary sclerosis</u>			<u>4 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug 25</u> , 19 <u>49</u> , to <u>May 29</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 28</u> , 19 <u>51</u> , and that death occurred at <u>2:10 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Arthur F. Jones</u>		DATE SIGNED <u>May 29, 1951</u>	
(Degree of title)		ADDRESS <u>110 S. Centre St.</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>5/31/51</u>	NAME OF CEMETERY OR CREMATORY <u>St Patrick Cem.</u>	LOCATION (City, town, or county) (State) <u>Cumberland, Md</u>
DATE REC'D BY LOCAL REG. <u>May 31, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Nantz, M.D.</u>	24. FUNERAL DIRECTOR <u>James F. Scarpelli</u> ADDRESS <u>Cumberland, Md</u>	

970000

RECEIVED
JUN 4 1951
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04465

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Allegheny</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>213 Maryland Ave</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Allegheny</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u> STREET ADDRESS (If rural, give location) <u>213 Md. Ave.</u>	
3. NAME OF DECEASED (Type or Print) First <u>Charles</u> Middle <u>Tarson</u> Last <u>Twigg</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>30</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 13, 1869</u>
9. AGE last birthday <u>81</u> yrs.		10. AGE last birthday If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. BIRTHPLACE (State or foreign country) <u>Oldtown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David C. Twigg</u>		14. MOTHER'S MAIDEN NAME <u>Melina Deffenbaugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Orain Twigg - Oldtown Md.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebro Vascular accident

INTERVAL BETWEEN ONSET AND DEATH

24 hr

Antecedent cause(s)

(b)

Arteriosclerosis & myocardial degeneration

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb, 1951, to May 30, 1951, that I last saw the deceased alive on May 30, 1951, and that death occurred at 7 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL/CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 3, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Twigg Cemetery</u>	LOCATION (City, town, or county) <u>Near Oldtown Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>June 1, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Hartz, M.D.</u>	24. FUNERAL DIRECTOR <u>John J. Hafer</u>	ADDRESS <u>Cumberland Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

100105

BUREAU V. 2

RECEIVED
JUN 4 1937

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>ALLEGANY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CUMBERLAND</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CUMBERLAND</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>305 Crawford St.</u>		STREET ADDRESS (If rural, give location) <u>305 Crawford St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JAMES</u>	(Middle) <u>L.</u>	(Last) <u>TWIGG</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MARCH 26, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building Construction</u>	9. AGE last birthday <u>63</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>DORBIN W.V.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis M. Twigg</u>		14. MOTHER'S MAIDEN NAME <u>SELINDA Stallings</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-10-6853</u>	
17. INFORMANT AND ADDRESS <u>MARY C. TWIGG 305 Crawford St.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Bronchogenic Carcinoma

INTERVAL BETWEEN ONSET AND DEATH

About

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4.27.51, 1951, to 5.21, 1951, that I last saw the deceasedalive on 5.20, 1951, and that death occurred at 9.55 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIED</u>	DATE THEREOF <u>5/23/51</u>	NAME OF CEMETERY OR CREMATORY <u>Greenmount Cem.</u>	LOCATION (City, town, or county) <u>Cumberland, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>May 28, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter K. Jantzi, M.D.</u>	24. FUNERAL DIRECTOR <u>JAMES F. SCARPELLI, Cumberland, Md.</u>		

510246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 29 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04467

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegheny Hospital</u>		STREET ADDRESS (If rural give location) <u>115 Harrison St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Frances</u>	(Middle) <u>Mae</u>	(Last) <u>Wilfong</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>28</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	8. DATE OF BIRTH <u>Nov. 28, 1914</u>	9. AGE last birthday <u>36</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Harry Thomas Heff</u>	
14. MOTHER'S MAIDEN NAME <u>Eva Mae Lowery</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT <u>Otis H. Wilfong, 115 Harrison St.</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>421.1</u>	(a) <u>Myocardial failure</u>	<u>2 mos.</u>
Antecedent cause(s) <u>92a</u>	(b) <u>Aortic valvulitis, old</u>	<u>? (20 years)</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Coronary ostial stenosis</u>	<u>? 6 mos.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypert thyroidism</u>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	(STATE)
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> m. Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1951, to May 28, 1951, that I last saw the deceased alive on May 26, 1951, and that death occurred at 8:28 A. a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 31, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	LOCATION (City, town, or county) <u>Cumberland, Md.</u>	(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>Walter K. Brantz, M.D.</u>	24. FUNERAL DIRECTOR <u>John J. Wapner</u>	ADDRESS <u>Cumberland, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 24 1951
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

04468

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>68 Mechanic St.</u>		STREET ADDRESS (If rural, give location) <u>68 Mechanic St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>IDA</u>	(Middle) <u>(HANSEL)</u>	(Last) <u>WINNER</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>6</u>	(Year) <u>1951</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>3-31-1867</u>
9. AGE last birthday <u>84</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William P. Hansel</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Barnard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Gorey McKenzie, Frostburg, Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Cerebral hemorrhage</u>		<u>3 weeks</u>
Antecedent cause(s)	(b) <u>Hypertensive Cardio-vascular Disease</u>		<u>years-</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE HOMICIDE		INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
TIME (Month) (Day) (Year) (Hour)		m.					

22. I hereby certify that I attended the deceased from Jan, 1951, to 6 May, 1951, that I last saw the deceased alive on 6 May, 1951, and that death occurred at 10:00 a.m., from the causes and on the date stated above.

SIGNATURE <u>John B. Davis, M.D.</u>		ADDRESS <u>Frostburg, Md.</u>		DATE SIGNED <u>5/8/51</u>	
23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)	
<u>Burial</u>	<u>5-9-51</u>	<u>Frostburg Memorial Park</u>	<u>Frostburg, Md.</u>		
DATE REC'D BY LOCAL REG. <u>5-9-51</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nancy N. Roe</u>		24. FUNERAL DIRECTOR ADDRESS <u>J. R. Durst, Frostburg, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 10 1961
BUREAU 118

MARYLAND STATE DEPARTMENT OF HEALTH

04469

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Midlothian</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Midlothian</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Midlothian, Md.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>James Edward Winters</u>		4. DATE OF DEATH <u>May 7, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 4, 1871</u>
9. AGE last birthday <u>80</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Midlothian, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John O. Winters</u>		14. MOTHER'S MAIDEN NAME <u>Ann Veronica Corrigan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Stephen J. Winters - Midlothian, Md.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Occlusion</u>		<u>Sudden</u>	
Antecedent cause(s) (b) <u>Arteriosclerosis</u>		<u>Several years</u>	
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE		INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Apr. 2, 1951</u> , to <u>May 7, 1951</u> , that I last saw the deceased alive on <u>May 2, 1951</u> , and that death occurred at <u>2:10 P.M.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Wm. E. Lane M.D.</u>		ADDRESS <u>Frostburg Md.</u> DATE SIGNED <u>5-8-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5-10-1951</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
DATE REC'D BY LOCAL REG. <u>5-10-51</u>		REGISTRAR'S SIGNATURE <u>Mrs. Mauley A. Roe</u>	
		24. FUNERAL DIRECTOR <u>Hafer Funeral Home</u> ADDRESS <u>Frostburg Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

093 688

RECEIVED
MAY 15 1951
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04470

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>PENNA.</u> <u>SOMERSET</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CUMBERLAND</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>MEYERSDALE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>ROUTE #2</u>	
3. NAME OF DECEASED (Type or Print) <u>SILAS</u> (First) <u>C</u> (Middle) <u>WITT</u> (Last)		4. DATE OF DEATH Month <u>MAY</u> Day <u>1</u> Year <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Nov. 10, 1868</u>
9. AGE last birthday <u>82</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher - Central Public School System</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>WILLIAM G. WITT</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA ANKNEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>MEMORIAL HOSPITAL CUMBERLAND, MD.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Broncho Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

3 days

Antecedent cause(s)

(b)

Generalized Arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Long advanced General ArteriosclerosisII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-27, 1951, to 5-1, 1951, that I last saw the deceasedalive on 5-1, 1951, and that death occurred at 6:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

093888

Meyersdale Pa
Main St.

RECEIVED

MAY 10 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>		STREET ADDRESS (If rural, give location) <u>244 E. Main St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ROSE</u>	(Middle) <u>MARGUERITE</u>	(Last) <u>YUNGERMAN</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>25</u>	(Year) <u>1951</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>2-23-1883</u>
9. AGE last birthday <u>68</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adam Wagner</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Lapp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>220-26-5511</u>	
17. INFORMANT AND ADDRESS <u>Alvin Kreiling, Frostburg, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Massive Cerebral Hemorrhage</u>	<u>12 hrs.</u>
Antecedent cause(s)	(b) <u>Hypertension</u>	<u>20 YRS.?</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Arteriosclerotic Cardiovascular disease</u>	<u>10 YRS.?</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>NONE</u>	19b. MAJOR FINDINGS OF OPERATION <u>✓</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>NONE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>✓</u>	(CITY OR TOWN) (COUNTY) (STATE) <u>✓</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>✓</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>✓</u>

22. I hereby certify that I attended the deceased from.....DEC......, 1950, to.....5/25....., 1951, that I last saw the deceased alive on.....5/25....., 1951, and that death occurred at.....4:20 A.M......, from the causes and on the date stated above.

SIGNATURE Martin W. Rothstein M.D. ADDRESS 48 Broadway - Frostburg, Md. DATE SIGNED 5/26/51

23. BURIAL, CREMATION, REMOVAL (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
Burial 5-27-1951 F'b'g. Memorial Park Frostburg, Md.

24. FUNERAL DIRECTOR ADDRESS
J. R. Durst, Frostburg, Md.

DATE REC'D BY LOCAL REG. 5-27-51 REGISTRAR'S SIGNATURE Mrs. Nancy A. Roe

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

320627

RECEIVED
MAY 31 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04472

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Clatonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Clatonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bear Hill Rd.</u>		STREET ADDRESS (If rural, give location) <u>Bear Hill Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Solomon David Zimmerman</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>May 6 1869</u>
9. AGE last birthday <u>81</u> yrs.		10. UNDER 1 year Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wood Ry.</u>	
11. BIRTHPLACE (State or foreign country) <u>Piney Plains Ind.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Zimmerman</u>		14. MOTHER'S MAIDEN NAME <u>Grakaney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Eugene L. Zimmerman, Clatonsville</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Myocardial Failure

Antecedent cause(s)

(b) Mitral Insufficiency
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May, 1950, to 1 May, 1951, that I last saw the deceasedalive on 1 May, 1951, and that death occurred at 9 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 7 51</u>	NAME OF CEMETERY OR CREMATORY <u>Clatonsville Cem.</u>	LOCATION (City, town, or county) <u>Clatonsville</u>	(State) <u>Ind.</u>
DATE REC'D BY LOCAL REG. <u>5/7/51</u>	REGISTRAR'S SIGNATURE <u>Mrs. A. E. C. Gineva</u>	FUNERAL DIRECTOR <u>Louis Stein Inc.</u>	ADDRESS <u>Cumberland</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

970506

RECEIVED
MAR 9 1951
BUREAU U. S.